

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3521

3521 63-024372

FILED JUL 5 1963

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	
Length of stay in lb <u>2 hrs.</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>LAKEVIEW HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>1735 NEWTON</u>	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>EVANGLIN</u> Middle <u>SUE</u> Last <u>HEITMAN</u>			4. DATE OF DEATH Month <u>6</u> Day <u>21</u> Year <u>1963</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-21-63</u>	9. AGE (last birthday) Months <u>0</u> Days <u>0</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE (INFANT)</u>			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (City and state or country) <u>KANSAS CITY, MISSOURI</u>			12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>CHARLES HEITMAN</u>			13b. MOTHER'S MAIDEN NAME <u>BONNA DRIVER</u>		
14. NAME OF HUSBAND OR WIFE <u>NONE</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go on or unknown) (If yes, give war or dates of) <u>NO</u>		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>CHARLES HEITMAN</u> Address <u>1735 NEWTON K.C., MO.</u>		

18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra uterine Asphyxia</u> DUE TO (b) <u>prolapsed cord -</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>atalectasis - intracranial hemorrhage</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour <u>10:29 A</u> Month, Day, Year <u>6-21-63</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>KANSAS CITY, MISSOURI</u>
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21. I attended the deceased from <u>6-21-63</u> to <u>6-21-63</u> and last saw her alive on <u>6-21-63</u> Death occurred at <u>10:29 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22. SIGNATURE (Degree or title) <u>James E. Griffin MD</u>		22b. ADDRESS <u>3900 Pershing Ave</u>		22c. DATE SIGNED <u>6/23/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>6/24/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK CEMETERY</u>		23d. LOCATION (City, town, or county) <u>KANSAS CITY, MISSOURI</u>
24. FUNERAL DIRECTOR <u>C.H. BLACKMAN & SON KANSAS CITY, MISSOURI</u>		25. DATE RECD. BY LOCAL REG. <u>6-24-63</u>		26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF James E. Griffin Medical Certification

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Bert B. Bennett

Licensed Embalmer No.

4656

P. O. Address

Kansas City, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his own handwriting.

If this body is not embalmed, fact should be so stated above.